State of Connecticut

GENERAL ASSEMBLY

PERMANENT COMMISSION ON THE STATUS OF WOMEN

18-20 TRINITY STREET
HARTFORD, CT 06106-1628
(860) 240-8300
FAX: (860) 240-8314
Email: pcsw@cga.ct.gov
www.cga.ct.gov/PCSW

Testimony of
Leslie Gabel-Brett, Ph.D.
Executive Director
Permanent Commission on the Status of Women
Before the
Human Services Committee
Tuesday, March 7, 2006

Re: HUSKY, SAGA, TANF, Housing, Child Care, Prescription Medications

Good morning Sen. Handley, Rep. Villano and members of the committee. My name is Leslie Gabel-Brett and I am the Executive Director of the Permanent Commission on the Status of Women. Thank you for this opportunity to testify on an array of proposed bills that affect the health and well-being of low-income families in our state.

In many ways, today's hearing is about the character of our state. Our state has great wealth, resources, and promise. As the state with the highest per capita income in the country, in a country with the greatest wealth in the world, we have a lot to feel good about. But as the members of this committee know well, we have two Connecticut's – one where families live in affluence, and one where they live in poverty. The poverty rate stood at 9.7% in 1995, and it is nearly unchanged ten years later (10%). As Connecticut Voices for Children report in their most recent publication, *Pulling Apart in Connecticut*, the gap between rich and poor families in our state is widening at a greater rate than in nearly all other states. The income of the wealthiest fifth of Connecticut families was 6.9 times the income of the poorest fifth in 2002. Even worse, Connecticut

is one of only two states in which the incomes of families in the poorest fifth actually declined between 1991 and 2002.[1]

The question before this committee today is: Will we continue to pull farther and farther in apart in Connecticut, or we will come together? Many of the proposed bills before you address the basic or urgent needs of individuals and families who have already fallen far behind; they do not necessarily prevent poverty or address its root causes. But still they are important, because until we help struggling families get health care, put food on the table, get a decent place to live and keep their children in school, they won't have a chance to lift themselves out of poverty and we won't have a chance to help them.

HUSKY and SAGA medical care, Temporary Family Assistance, Care4Kids, ConnPACE, supportive housing – these are not just budget lines, they are life lines.

SB 475 AAC Revisions to the HUSKY Plan, Part A and Part B

PCSW supports the passage of SB 475, which restores in the HUSKY Plan, Part A and Part B, continuous eligibility for children and self-declaration of participant income, appropriates money to the Department of Social Services for public information and outreach activities regarding the program, and eliminates cost-sharing requirements of the HUSKY Plan, Part A.

HUSKY is of great concern to the PCSW because the majority of the approximatel 90,000 adults on HUSKY A are women caring for themselves and their children.

When continuous eligibility for children was eliminated in 2003, over 7,000 children lost HUSKY coverage. Since last July, when self-declaration of income was eliminated, there are 10,000 fewer enrollees in HUSKY. These are measures that pulled us farther apart and increased the number of low-income people who do not have health insurance. Restoring continuous eligibility and self-declaration of income will help more low-income families get and keep HUSKY health care coverage.

Continuous eligibility minimizes the amount of cycling in and out of HUSKY enrollment by allowing children to maintain coverage in HUSKY for up to one year from enrollment or renewal despite temporary income fluctuations. Inconsistent enrollment results in medical coverage gaps, which are becoming more common and growing longer. Nationally, 40% of those enrolled in Medicaid/SCHIP were found to cycle on and off coverage.[2]

Self-declaration of income and the subsequent electronic verification through the Department of Labor, Social Security, and other electronic records increases efficiency

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[1] Connecticut Voices for Children, *Pulling Apart in Connecticut*, January 2006

[2] M. Birnbaum and D. Holahan, Renewing Coverage in NewYork's Child Health Plus B program: Retention Rates and Enrollee Experiences. New York: United Hospital Fund, 200; and K. Lipson et al, Rethinking Recertification: Keeping Eligible Individuals Enrolled in New York's Public Health Insurance Programs, Pub. No. 656. New York: Commonwealth Fund, August 2003.

and productivity by minimizing duplicate paperwork and streamlining fraud checks.[3] After using this process for four years, self-declaration and electronic verification of income were eliminated in July 2005 and resulted in the loss of HUSKY coverage for 10,000 people. Due to the more cumbersome procedures, one-third of medical assistance requests, which include HUSKY applications, are now overdue. Delays frequently violate federal law, which requires states to complete the eligibility determination within 45 days, and were cited as a problem by the Legislative Program Review and Investigations Committee report.

Intended to save state funds, these shifts in enrollment procedures are actually costly. The substantial administrative costs incurred in re-determining HUSKY eligibility were estimated at $1 million. Additionally, the loss of continuous eligibility and self-declaration of income cost member hospitals an estimated $2.8 million.[4] These costs of uncompensated care are absorbed and transferred to the privately insured. The actual cost of the changes in HUSKY enrollment procedures were approximately $4 million, resulting in an approximate 50% reduction in the original savings estimates.

We also support the proposal to fund outreach and enrollment efforts. State and national experiences demonstrate that providing outreach at targeted locations, such as schools, community health centers, and other provider sites, increases enrollment. Additionally, one-on-one outreach is critical. Outreach efforts must focus on *retention* as well as enrollment given the complexity of the program.

We strongly support the repeal of language authorizing DSS to impose premiums and co-pays on HUSKY A adults with incomes between 100% and 150% of the federal poverty level ($16,090 to $24,135 per year for a family of three). As seen in Connecticut's recent experience with imposing higher cost sharing on HUSKY B children, cost sharing causes drops in enrollment, thereby keeping *eligible* working parents and caretaker relatives off the HUSKY program. In fact, each time the state gets to the brink of imposing higher cost-sharing on low-income families, the legislature and Governor repeal the authorization to avoid terminating coverage for families. Authorization for premiums and co-pays for HUSKY A parents should be repealed now, thereby preventing the confusion and administrative burdens that have plagued HUSKY B for two consecutive years.[5] We need to increase enrollment, not decrease it. Healthy children need healthy parents.

SB 478 AAC Revisions to the State-Administered General Assistance Program

PCSW supports the passage of SB 478, which strengthens access to health care services for very poor adults without children and ensures the provision of transportation services to participants.

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[3] T. Westmoreland, Director, Center for Medicaid and State Operations and M. Mangano, Acting Inspector General, Office of the Inspector General, Letter to State Medicaid Director, Health Care Financing Administration, January 19, 2001.

[4] Connecticut Hospital Association, 2004

[5] In November 2005, the legislature repealed the new and increased premiums on HUSKY B children due to the inability of many HUSKY B families to pay the higher costs.

SAGA Medical provides health care for approximately 31,000 of Connecticut's poorest residents. Health care coverage through SAGA is critical to low-income women in Connecticut, as 40% of the recipients are women.[6] Access to medical services that are covered under this program are limited. SAGA Medical income eligibility is extremely stringent. The income ranges from $5,714 to $6,898 *per year* and cash assets are limited to about $1,000. (Income and asset rules vary depending on the region of the state.)

Non-emergency medical transportation to allow covered individuals to get to and from medical appointments is currently not provided. Many SAGA beneficiaries are disabled and do not have transportation. Some are waiting for a final SSDI/SSI and Medicaid eligibility determination to obtain coverage that would provide transportation. This process can take eight months to two years to complete. Health care may be available, but not accessible. Requiring people to go to Federally-Qualified Health Centers (FQHCs) often means people have to travel very long distances to see a doctor.

Funds for the provision of transportation services minimize health care expenditures. Inappropriate ambulance transportation is common among Medicaid and SAGA populations but would be minimized by the provision of alternate forms of transportation.[7] Participants without transportation assistance are less likely to use health care services leading to more severe health conditions associated with higher health care costs.[8]

SB 477 AAC The Availability of Optional Services Under the Medicaid Program

We support restoration of optional services under Medicaid in order to provide a more comprehensive package of benefits for low-income, elderly and disabled participants, the majority of whom are women. These services include those provided by chiropractors, naturopaths, podiatrists, psychologists, optometrists, and others.

In addition, the PCSW supports the proposed state plan amendment which would provide coverage for periodontal screens and treatment for pregnant women in HUSKY. Pregnancy represents a time of greater risk to women's oral health. According to the American Academy of Periodontology, about half of pregnant women acquire gingivitis during pregnancy. Studies have shown a relationship between periodontal disease and preterm, low birth weight babies. In fact, pregnant women with periodontal disease may be seven times more likely to have a baby that is born too early and too small. Periodontal services are positive preventive measures that help protect women's health and prevent poor birth outcomes or costly preterm births.

HB 5636 AAC Revisions to the ConnPACE Program

PCSW and the Connecticut Women's Health Campaign support the reduction of the ConnPACE copayment from $16.25 to $10.25 per prescription. The majority of

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[6] DSS Data.

[7] Kost S. & Arruda, J. (1999). Appropriateness of ambulance transportation to a suburban pediatric emergency department. Prehospital Emergency Care. Jul-Sep;3 (3) :187-90.

[8] Bloom, B. & Jacobs, J. (1985). Cost effects of restricting cost-effective therapy. Medical Care, 23 (7): 872-80.

Medicare and ConnPACE consumers are women. There are at least 257,252 women over the age of 65 in Connecticut. The majority of our elderly (59%) are women.[9] Assuming that the proportions of women participating in national Medicare programs are similar to the participation rates in Connecticut, we estimate that 55-70% of ConnPACE participants or 28,000-35,000 are elderly women. More elderly women than men rely on life-saving medications, and older women tend to be more burdened by prescription drug costs than men.

Requiring high cost-sharing for low-income elderly women relying on life-saving drugs is not good medicine or good policy. Numerous studies have shown that even modest co-payments can deter low- and moderate-income individuals from getting preventive care, including prescription drugs.[10] A study published in the journal *Health Affairs* found that elderly and disabled Medicaid participants in states with prescription co-payments were less likely to use prescription drugs than those in states without co-pays.[11] The proposed bill to reduce cost-sharing for ConnPACE participants is supported by research that shows that elderly participants are more likely to access preventive pharmaceutical care with lower co-payments.

HB 5637 AAC the Availability of a Temporary Supply of a Brand Name Prescription Drug in Emergency Situations

PCSW urges your support for this consumer protection bill, but asks that you amend it to strengthen consumer protections for prior authorization under Preferred Drug Lists, not just for prior authorization where a name brand drug with generic equivalents has been prescribed. Consumer protections are needed for all drugs where prior authorization is required, not only those needed in an "emergency."

HB 5641 AAC Revisions to the Medicaid Program

The PCSW supports the proposal to raise the medically needy income level, remove the upper age limit in the personal care assistance program for the disabled, and restore the period of transitional medical assistance (TMA) to two years. These changes would help more families obtain and keep Medicaid coverage and services.

Transitional Medical Assistance (TMA) helps whole families keep HUSKY coverage in spite of fluctuations in income. Families whose income puts them over the HUSKY A income guidelines of 150% of FPL ($24,135 per year for a family of three), keep their HUSKY coverage. TMA used to provide up to 24 months of continued HUSKY A coverage. In 2005, TMA was reduced from two years to one year.

A small percentage of HUSKY A families (less than 20% according to last year's DSS enrollment files) are receiving cash assistance. Many more HUSKY A enrollees are

[9] Current Population Survey, 2004.
[10] Jan VanTassel, Connecticut Legal Rights Project. Testimony Before the Connecticut General Assembly's Appropriations, Human Services, Public Health and Aging Committees on Medicare Part D. November 9, 2005.
[11] B. Stuart and C. Zacker, "Who Bears the Burden of Medicaid Drug Copayment Policies?" *Health Affairs*, March/April 1999.

in working families with incomes below the poverty level. Currently, about 46,000 individuals are enrolled in HUSKY A through TMA.

While the primary source of health insurance is through employers for most adults in Connecticut, low-income workers are much less likely to have employer-sponsored coverage. A recent study found that only 8 percent of low income adults have the possibility of obtaining employer-sponsored insurance.[12] Those most deeply affected by the reduction in TMA are low-income working women who do not have employer-sponsored coverage. Nationally, over 30% of working women who left cash assistance remained uninsured after working for the same employer for 2 years or more.[13] Over half of women who leave welfare report at least one health problem. 22% of women said they had a health condition that limits the type or amount of work they can do.[14]

Health coverage, especially through TMA, is a vital work support for working families and a major boost to family economic security.

SB 481 An Act Concerning A Medicaid Home and Community-Based Service Waiver for Persons With Human Immunodeficiency Virus or Acquired Immune Deficiency Syndrome and **HB 5642, AAC Programs Administered by the DSS**

We support the two proposed bills that would expand services for those with human immunodeficiency virus or acquired immune deficiency syndrome. SB 481 would allow access to home and community-based services to 100 patients diagnosed with human immunodeficiency virus or acquired immune deficiency syndrome and who are at risk for institutionalization in the absence of such services. PCSW and the CWHC support expanded access to services particularly for women with HIV/AIDS and ask that some of these slots be reserved for women. HB 5642 includes a provision that would expand the availability of state insurance payments on behalf of those with HIV/AIDS.

R.B. 479, AAC Revisions to the Temporary Family Assistance Program

This proposed bill makes four important revisions to the rules governing the provision of cash assistance under the Temporary Family Assistance Program. First, it expands the definition of individuals exempt from time limits to include those who, due to a medical impairment, are unable to work a sufficient number of hours to earn at least as much as the welfare payment standard. Advocates and counselors who assist TFA recipients have found that some recipients have cognitive or medical impairments that make it impossible for them to work and earn enough to live. Such recipients should not be subject to the 21-month time limit.

Second, the bill allows the Department of Social Services to grant six-month extensions up to the maximum of 60 months of benefits permitted under federal law to families who are complying with program requirements but still have income below the

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[12] S. K. Long and J. A. Graves, *What Happens When Public Coverage Is No Longer Available?* The Urban Institute for the Kaiser Commissionon Medicaid and the Uninsured. January 2006.
[13] B. Garrett and J. Hudman, "Women who left welfare: health care coverage, access and use of health services." Kaiser Commission on Medicaid and the Uninsured, June 2002.
[14] B. Garrett and J. Hudman, "Women who left welfare: health care coverage, access and use of health services." Kaiser Commission on Medicaid and the Uninsured, June 2002.

payment standard or have encountered serious barriers to employment such as domestic violence. Currently, DSS is allowed to grant only two six-month extensions to families whose income has not reached the payment standard; after that, regardless of the efforts or the income of the family, benefits must be terminated. We know that some participants need more time to learn to read, get a GED or learn a job skill and, as long as they are participating in good faith and complying with program requirements, we should avoid wasting their efforts and public dollars by simply cutting them off too soon.

Third, the proposed bill eliminates the so-called "family cap" that reduces benefits by 50% to families when a child is born ten months or more after the family is enrolled in the TFA program. This existing policy only has the effect of penalizing a family with a newborn child by making a small cash payment even smaller.

Finally, the bill corrects an anomaly in the current law: Non-cash safety net services are currently available only to families who lose benefits because of sanctions. The proposed bill would make safety net services available also to families who lose benefits because they have reached the end of time limits but are still not earning income equal to the welfare payment standard. Such families have complied with all the program requirements yet are still not able to earn sufficient income – these families are in great need of continuing safety net services.

R.B. 476, AAC Concerning the Supportive Community Housing Pilot Project for Recipients of Temporary Family Assistance

We strongly support the concept of supportive housing for recipients of TFA. Recently, several women living in a homeless shelter and receiving welfare benefits came to our offices at the PCSW seeking job training assistance. They, like many other recipients of state assistance, were anxious to find a secure place to live, learn a skill and get a decent job. The PCSW would be pleased to collaborate in developing job training and other programs to meet the needs of women in supportive housing.

R.B. 480, AAC Child Care

We support this bill to increase the reimbursement rates to child care centers and to achieve parity between funding levels for state-funded centers and school readiness programs. All children are of equal value, regardless of which child care program they attend, and therefore the state should invest equally in the quality of their early care and education.

As you know, professionals in the field of early care and education perform the most important work – caring for and beginning the education of our youngest children – and yet are paid very low wages, and rarely receive benefits. According to a report released last November by the Child Health and Development Institute of Connecticut, one in five childcare centers had no teachers with at least a bachelor's degree. The median income for full-time teachers was only $24,000 per year, and as little as $17,000 for assistant teachers and aides. The assistant teachers and aides have a turn-over rate as

high as 20% within a 12-month period.[15] This is unfair to the workers, and also diminishes the quality of care and education provided to children.

Increasing funding to child care centers will make it possible for them to increase compensation for teachers, thereby reducing the otherwise high turnover rate in this field. The end result will be better outcomes for children and greater economic security for workers.

[15] Connecticut Health and Development Institute of Connecticut, *Shaping Young Lives: A Profile of Connecticut's Early Care and Education Workforce*, November 2005, p. 6